STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155566	B. WIN			04/18/2	011
			D. (111)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	PRAIRIE ST		
	V MEADOWS CARE	ECENTER			AW, IN46580		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
K0000							
	A 1.15 G G G	1 B	1/20	1000			
	A Life Safety Code Recertification		K	0000			
	and State Licensure Survey was						
	conducted by tl	he Indiana State					
	Department of	Health in					
	accordance witl	h 42 CFR 483.70(a).					
	Survey Date: 0	4/18/11					
	survey succ. o	.,,					
	Facility Number	~: 0002E0					
	· •						
	Provider Numbe						
	AIM Number: 1	100274920					
	Surveyor: Amy	Kelley, Life Safety					
	Code Specialist						
	•						
	At this Life Safe	ety Code survey,					
		ws Care Center was					
	found not in co	•					
	-	or Participation in					
	Medicare/Medi	caid, 42 CFR					
	Subpart 483.70)(a), Life Safety					
	from Fire and t	he 2000 edition of					
	the National Fir						
		FPA) 101, Life Safety					
		apter 19, Existing					
		cupancies and 410					
	IAC 16.2.						
	This one story	facility was					
	determined to l	be of Type III (211)					
	construction in						
		- J					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1JYV21

Facility ID:

000359

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155566		(X2) MULTIPL A. BUILDING B. WING	e construction 01	l' '	E SURVEY PLETED 2011	
	PROVIDER OR SUPPLIER		300	EET ADDRESS, CITY, STATE, 2 E PRAIRIE ST RSAW, IN46580	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO	ITON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	and laundry win (111) construct sprinklered. The alarm system with detection in the areas open to the facility has a call had a census of this survey. Quality Review by I Safety Code Special 04/27/11. The facility was compliance with aforementioned.	e corridors and he corridors. The pacity of 100 and f 67 at the time of Robert Booher, REHS, Life ist-Medical Surveyor on found not in h the				

000359

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155566		(X2) MU A. BUILI B. WING	DING	01	(X3) DATE S COMPL 04/18/20	ETED	
	PROVIDER OR SUPPLIER			300 E PF	DDRESS, CITY, STATE, ZIP CODE RAIRIE ST W, IN46580		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
K0018 SS=E	than required enclexits, or hazardous doors, such as the solid-bonded core resisting fire for at sprinklered buildin resist the passage impediment to the are provided with a keeping the door of meeting 19.3.6.3.6. Roller latches are regulations in all had 1, Based on obtainterview, the fensure 1 of 14 doors protecting openings on Had close and latch frame. This decould affect am residents on the Findings included Based on obsert Maintenance Did 18/11 at 1: corridor door to failed to latch in This was acknown.	prohibited by CMS ealth care facilities. pservation and acility failed to resident room ag corridor armony hall would into the door ficient practice y of the 15 e Harmony hall. e: evation with the irector on 35 p.m., the o resident room 15 nto the door frame. wledged by the irector at the time	K00	018	This plan of correction is to serve as Warsaw Meadows Care Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Warsaw Meadows Care Center or its management company of at conclusion set forth in the statement of deficiencies or any violation of regulation. K018 NFPA 101 Life Safety Code Standard It is the pract of Warsaw Meadows Care Center to ensure that it provides the best care possible. In accordance with that policy, we have address the following issues: A. The resident's bed in room 15 of Harmony Hall was causing a corridor door to not close a latch into the door frame. Example was moved to ensure door closes and latches into the	ute ny ctice th sed e n the nd	05/18/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1JYV21 Facility ID:

000359 If continuation sheet

Page 3 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155566	B. WIN	IG		04/18/2011
NAME OF I	PROVIDER OR SUPPLIEF	}		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
	THE VIBER ON BOTTERE			300 E P	PRAIRIE ST	
WARSAV	W MEADOWS CAR	E CENTER		WARSA	AW, IN46580	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	3.1-19(b)				door frame on 05/04/2011.	-
					corridor door to resident ro	
	2. Based on observation and				on Memory Lane was fixed 4/19/2011 and no longer has	
	interview, the f	acility failed to			four pencil size holes near	
		doors protecting			top. No negative outcomes	
		ngs were smoke			were found that could have	
	· ·	mory Lane. This			affected any of the resident	s.
		ice could affect all			B. An Audit tool was creat	
	· ·				on 05/04/2011 to ensure that	
	21 residents in	Memory Lane.			doors are being checked for	I
					holes and are providing the proper smoke barrier per L	
	Findings includ	le:			Safety Standard. The Audit	
					tool is also used to ensure	
	Based on an ob	servation with the			no one is putting trash	
	Maintenance D	irector on			containers, beds, or any ot	her
	04/18/11 at 1	:50 p.m., there were			items in front of the doors	hat
		e holes near the top			would cause the door not to	
	I	door to resident			close and latch into the dod	or
					frame. A Monthly	
		emory Lane. This			Environmental Rounds too was created that the	
		by the Maintenance			Maintenance Director and	
	Director at the	time of			Administrator will use toge	ther
	observation.				each month for the Safety	
					Committee Inspection. C.	The
	3.1-19(b)				Maintenance Director has b	
					educated to the use of the	new
					Audit tool and Monthly	
					Environmental Rounds too	
					All employees were provide education on smoke barrie	
					and ensuring beds, curtain	· ·
					trash containers, etc are no	•
					left in front of doors, and th	ie
					proper procedures for notif	
					the Maintenance Director o	r
					designee if issues are	
					discovered. This was	

000359

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155566		(X2) MULTIPLE CO A. BUILDING B. WING	01	COMI 04/18/	E SURVEY PLETED 12011	
NAME OF P	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP	CODE	
WARSAV	V MEADOWS CAR	E CENTER		W, IN46580		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K0029 SS=E	fire-rated doors) o extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no	d construction (with ³ / ₄ hour r an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. ed automatic fire em option is used, the areas n other spaces by smoke and doors. Doors are on-rated or field-applied nat do not exceed 48 inches		completed on May The Maintenance E audit all the doors 18, 2011. The Maint Director will provic from the new Audit Administrator for r Results of the More Environmental Rounew Audit tool will monthly by the Quance Commit overseen by the Actor ensure continue compliance. E. Th Administrator is re We will be in comp May 18, 2011.	Director will prior to May tenance de results t tool to the review. Inthly unds and the be reviewed ality ttee and dministrator ed e esponsible.	
		the door are permitted.	K0029	K029 NFPA 101 Life	-	05/18/2011
	hazardous area heater rooms a storage areas o in size, were se	idor door to 3 of 3 as, such as water nd combustible over 50 square feet alf closing and a door frame. This		code Standard A. closing device was the corridor door to heater room in the Administrator hall 05/10/2011. A new device was installe corridor door to the heater room in the Lane that was miss	on v self closing ed to the water	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	01	COMPLETED)
		155566	B. WIN			04/18/2011	
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R		1	PRAIRIE ST		
WARSA	W MEADOWS CAR	F CENTER			AW, IN46580		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re CO	MPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
residents in the Administration				screw. This was completed 04/20/2011. The corridor do	I .		
	hall, Memory L	ane and the north			to the Medical record/stora		
	Central hall.				room, containing cardboard	- I	
					boxes of medical records, v	I .	
	Findings includ	łe·			fixed on 04/27/2011 so that	I .	
	Thidings include.				now latches into the frame.	No	
	Dacad are are all	acominations with the			negative outcomes were fo	und	
		oservations with the			that could have affected an	y of	
	Maintenance D				the residents. B. An Audit	iool	
	04/18/11 fron	n 1:06 p.m. to 2:00			was created on 5/04/2011 to	,	
	p.m., the follow	wing was noted:			ensure that all hazardous		
	a) the corridor	door to the water			doors have been identified	l l	
	heater room in	the Administrator			have a self-closing device i		
	hall was not ec	quipped with a self			place. C. The Maintenance Director was educated to the		
	closing device.				use of the new Audit tool.	-	
	_				employees received educa		
		missing from the			on the importance of filling	I .	
	1	vice on the corridor			a maintenance request form	I .	
	door to the wa	ter heater room in			soon as possible to ensure	I .	
	the Memory La	ne and it was no			all issues are handled prom	iptly	
	longer function	nal.			by the Maintenance Directo	r or	
	c) the corridor	door to the Medical			designee. This was comple	ted	
	'	room containing			on May 9, 2011. D. The		
	cardboard box				Maintenance Director and	_	
					Administrator will inspect a		
		f close, but failed to			hazardous areas the first w then will inspect monthly	ECK,	
	latch into the f				during the Safety Committe		
	These problem	is were confirmed			Inspection, using the Montl		
	by the Mainten	ance Director at the			Environmental Rounds too	• 1	
	time of observ	ations.			Results of the Monthly		
					Environmental Rounds and	the	
	3.1-19(b)				new Audit tool will be revie	wed	
					monthly by the Quality		
					Assurance Committee and		
					overseen by the Administra	tor	
					to ensure continued		
					compliance. E. The		

000359

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE SUF	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLETED	
		155566	B. WIN			04/18/201	1
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				PRAIRIE ST		
WARSAV	V MEADOWS CARE	ECENTER			AW, IN46580		
(VA) ID	CLD O A A DV C	TATEMENT OF DEPLOYENCIES	_		,		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E C	DATE
1110	REGULATOR		+	1110	Administrator is responsibl		DATE
					We will be in compliance by		
					May 18, 2011		
K0046	Emergency lighting	g of at least 1½ hour	1		,,		
SS=C		ed in accordance with 7.9.					
	19.2.9.1.						
	Based on obser	vation and record	K(0046	K046 NFPA 101 Life Safety	(05/18/2011
	review, the faci	lity failed to ensure			Code Standard		
	•	jency lights were			A All &		
	_	for at least a 1 1/2			A. All fourteen battery operated emergency lights will be tested by May 18, 2011.		
	-	n accordance with					
				be tested by may 10, 2			
	LSC 7.9. LSC 7.9.3 Periodic		1		No negative outcom	es	
	_	rgency Lighting			were found that could have		
		uires an annual test			affected any of the resident	s.	
	shall be conduc						
	required batter	y powered			B. An annual emergency	ight	
	emergency ligh	t for not less than a			test tool was developed identifying each emergency		
	1½ hour durat	tion. Equipment			light and	' l	
	shall be fully or	perational for the			that at least 1 ½ hour durati	ion	
	duration of the	test. Written			is provided in accordance v		
	records of visua	al inspections and			Life Safety Code 7.9. Task	to	
		ept by the owner			ensure annual testing is do	ne	
		by the authority			was added to the	.	
	=	ion. This deficient			Environmental Rounds Too	'	
					checklist for December of		
	practice could a	affect all occupants.			every year.		
					C. The Maintenance Direc	tor	
	Findings includ	e:			was educated on the new		
					Annual Emergency Light Te	st	
	Based on obser	vations with the			tool.		
	Maintenance Di	rector on					
	04/18/11 from	12:55 p.m. to 3:00			D. The Maintenance Direc		
		battery operated			will provide results from the Audit tool to be reviewed	•	
	-	ts were observed			monthly by the Quality		
	throughout the				Assurance Committee and		
	anoughout the	racinty.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155566	B. WING		04/18/2011
NAME OF I	PROVIDER OR SUPPLIER		l	ADDRESS, CITY, STATE, ZIP CODE	
WARSA	W MEADOWS CARE			PRAIRIE ST AW, IN46580	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	overseen by the Administra	DATE
	Emergency ligh			to ensure continued	
	during tour of t	-		compliance.	
worked. During record review at 12:55 p.m. on 04/18/11, the					
			E. The Administrator is		
	Maintenance Di			responsible. We will be in compliance by May 18, 201	1
	provide a writte			Compliance by May 10, 201	'
	·	arding the battery			
	operated emer	gency lights.			
	3.1-19(b)				
	(-,				
K0056 SS=E	installed in accord Standard for the Ir Systems, to provice portions of the built properly maintaine 25, Standard for the Maintenance of W Systems. It is fully reliable, adequate system. Required equipped with wat switches, which are the building fire also Based on obsertinterview, the frensure 2 of 2 standard from at least six feet NFPA 13. NFPA 15–6.3.4 required located no clos measured on control of the province of the systems of the	vation and acility failed to prinklers in the were separated by as required by a 13, Section es sprinklers be er than six feet	K0056	K056 NFPA Life Safety Cod Standard A. 1 of the 2 sprinklers located in the smoking roo has been removed in order meet the required Life Safe Code Standard. This was completed on 05/03/2011. No negative outcomes were found that could have affectany of the residents.	m to ty

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155566		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 04/18/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and the Center event of an em Findings includ			B. All sprinklers through facility will be inspected to ensure they meet Life Safe Code specifications. C. The Maintenance Direct will be educated to proceed and documentation by	etor
	located five fee	05 p.m., the had two sprinklers t apart. This was by the Maintenance		and documentation by 5/13/2011. D. An Audit of all sprinkle throughout facility will be conducted to ensure all sprinklers are inspected by May 18, 2011 to ensure the meet Life Safety Code specifications. The sprinkler heads will then be inspected weekly x 4 weeks, then monthly for 5 months and ongoing. The Maintenance Director will provide documentation of inspectic to be reviewed monthly by Quality Assurance Commit and overseen by the Administrator to ensure	er ed ons the
K0130	OTHER LSC DEF	CIENCY NOT ON 2786		continued compliance. The Administrator is responsible. We will be in compliance by May 18, 201	1
SS=E	Based on obser interview, the for ensure 2 of 3 p fire barrier wall	acility failed to enetrations of the	K0130	K130 NFPA101 Miscellaned A. There were two unseald penetrations around a springline measuring three inches and around a conduit pipe	ed nkler s

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLE	TED
		155566	B. WIN			04/18/20 ⁻	11
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			PRAIRIE ST		
WARSA	W MEADOWS CAR	E CENTER			AW, IN46580		
			_		,		(37.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	1.	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re l'	DATE
			1		measuring one inch. There	is	
	Administration hall and Harmony				no longer a penetration. Th		
	hall were prote	·			was an unsealed penetration	n	
		ce designed for the			measuring one inch around	la	
	1 ' ' '	se and capable of			sprinkler line. There no lon	- 1	
	1	e fire resistance of			is a penetration. B. A tool		
	the barrier. LS	C 19.1.1.3 requires			created to ensure that pipe		
	all health care	facilities to be			conduits, bus ducts, cables wires, air ducts, pneumatic		
	maintained and	d operated to			tubes and ducts, and simila		
	minimize the p	ossibility of a fire			building service equipment		
	emergency req	uiring the			that pass through fire barri	ers	
		he occupants. LSC			shall be protected per Life		
	8.2.3.2.4.2 reg	•			Safety Code standards. C.	The	
		ducts, cables, wires,			Maintenance Director was	.	
		matic tubes and			educated on the Life Safety Code 8.2.2.2.4.2 requirement		
					A Protocol was developed t		
		ilar building service			the Maintenance Director w		
	1 .	t pass through fire			follow any vendor contracte	ed	
	barriers shall b	e protected as			that provides work in the at	tic	
	follows:				to ensure there are no		
	(1) The space b				unsealed penetrations. D.		
	penetrating ite				Maintenance Director will a all areas of potential conce	I .	
	barrier shall m	eet one of the			prior to May 18, 2011 and th	I .	
	following cond	itions:			weekly for 4 weeks, then		
	a. It shall be fil	led with a material			monthly for 5 months and t	hen	
	that is capable	of maintaining the			ongoing. The Maintenance		
		of the fire barrier.			Director will provide results		
	b. It shall be pi				be reviewed monthly by the		
	· ·	te that is designed			Quality Assurance Commits and overseen by the	.ee	
	for the specific				Administrator to ensure		
	•	penetrating item			continued compliance.E. T	he	
	•	o penetrate the fire			Administrator is responsibl		
		•			Date of compliance is May	18,	
		eve shall be solidly			2011.		
		parrier, and the					
	space between	the item and the					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155566	A. BUILD	ING	01	COMPL 04/18/2	
		133300	B. WING	CED FEET A	DDDDGG GETY GTATE ZID GODE	04/10/2	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WARSAV	W MEADOWS CARE				W, IN46580		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	sleeve shall me	· · · · · · · · · · · · · · · · · · ·	1	IAG	,		DAIL
	following conditions: a. It shall be filled with a material						
		of maintaining the					
	· ·	of the fire barrier.					
	b. It shall be pr						
	· ·	e that is designed					
	for the specific	-					
	· ·	purpose. Practice could affect					
		the front office					
		ninistration hall and					
	15 residents or						
	1 3 residents of	i mannony nan.					
	Findings includ	e:					
	Based on obser	vations with the					
	Maintenance Di	irector on					
	04/18/11 from	2:45 p.m. and					
	3:00 p.m., the	following					
	penetrations w	ere in both attic fire					
	barrier walls of	the Administration					
	hall and Harmo	•					
	· ·	ire barrier wall on					
		tion hall there were					
	· ·	enetrations around					
	· ·	measuring three					
		und a conduit pipe					
	measuring one						
	b) at the attic f						
	_	ony hall from the					
	Administration	hall there was an					
	I	ration measuring					
	one inch aroun	d a sprinkler line.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155566	B. WIN			04/18/2	011
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	Based on an int	terview with the					
	Maintenance Su	pervisor at the					
	time of observation, the walls were						
	fire barrier wall	s.					
K0144 SS=C			KO	0144	K144 NFPA 101 Life Safety		05/18/2011
			failed to Code Standard		1		03/16/2011
		•					
	emergency gen power to the er systems. LSC 7 99, Health Care 3-4.1.1.8 requi- set shall have s to pick up the I minimum frequi- stability require emergency syst seconds after lo power. This de affects all occu	for testing 1 of 1 perators providing mergency lighting 7.9.2.3 and NFPA re Facilities, peres the generator sufficient capacity oad and meet the pency and voltage rements of the peres within 10 poss of normal reficient practice pants			A. A stopwatch was purchased to ensure month load test record indicating that transfer of power from the main source to the emerger generator doesn't take long than 10 seconds. No negative outcomes were found that could have affect any of the residents. B. The Maintenance Direct contacted Dickerhoff Electric the vendor who inspects outgenerator, and they instruct the Maintenance Director as how to adjust it. A monthly load test log was created to ensure the transfer of power from the main source to the emergency generator is not taking any more than 10.	the ncy ger eted ctor ic, ur ted s to	
		the Maintenance			taking any more than 10 seconds.		
	•	/18/11 at 12:40			Jooding.		
	/	•	1			,	l l

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

i '		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155566	A. BUILDING B. WING		COMPI	COMPLETED 04/18/2011	
NAME OF PROVIDER OR SUPPLIER WARSAW MEADOWS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN46580				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
IAU	p.m., the mont indicated the trefrom the main emergency generation than ten second of February and was confirmed	hly load test record ransfer of power	IAU	C. The Maintenance was educated to the m frequency and voltage requirements of the ensystem within 10 secoloss of normal power. D. The Maintenance will provide monthly lot to the Administrator for and signature. The Maintenance Director provide all information log to be reviewed mothe Quality Assurance Committee and overse the Administrator to electronic continued compliance E. The Administrator responsible. We will be compliance by May 18	Director inimum stability nergency nds after Director oad test or review will ofrom nthly by en by nsure is e in	DATE	